

1  
one

WELCOME

ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS# \_\_\_\_\_

Home Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: \_\_\_\_\_

Other Phone #s: \_\_\_\_\_

e-mail: \_\_\_\_\_

May we send our informational newsletter and event announcements (infrequently) to your e-mail address? **Yes No**  
(we will never sell your e-mail address to anyone ever)

Referred By:  Current Patient: Name: \_\_\_\_\_

Yellow Book  Verizon Book  Website  Other \_\_\_\_\_

Employer & Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_ Work Phone # \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

2  
two

OFFICE USE ONLY

Co. Name: \_\_\_\_\_

Benefits Available? Yes NO

COPAY: \_\_\_\_\_

Deductible: \_\_\_\_\_

Patient Coinsurance: \_\_\_\_\_%

Benefit Limits: \_\_\_\_\_

Other Info: \_\_\_\_\_

REASON FOR VISIT

Have you ever been treated by a Chiropractor?  Yes  No

Have you ever been treated by a Naturopathic Physician?  Yes  No

If so, when?: \_\_\_\_\_

What did you see them for? \_\_\_\_\_

Are your primary complaints the result of an automobile accident, work injury, or other cause (please circle one)?

What is your primary goal in seeking care here: \_\_\_\_\_

Circle your desire to reach this goal (10 highest): 0 1 2 3 4 5 6 7 8 9 10

When did condition begin? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine.

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

What other treatments have you attempted for this condition? \_\_\_\_\_

3  
three

PLEASE CONTINUE ON BACK

## REASON FOR VISIT CONTINUED

What is your secondary goal in seeking care here: \_\_\_\_\_

Circle your desire to reach this goal (10 highest): 0 1 2 3 4 5 6 7 8 9 10

When did condition begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

What other treatments have you attempted for this condition? \_\_\_\_\_

(If you have additional goals, please write them on the blank side of the form.)

What type of care are you NOT interested in, if recommended to help you:

- Chiropractic  Dietary Recommendations  Nutritional Supplements  
 Acupressure  Herbs  Exercises  Detoxification

CONTINUED FROM FRONT

3  
three

4  
four

## DIETARY AND LIFESTYLE

List the 5 foods (including drinks) you consume most often BE HONEST!!:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

How much water do you drink a day (in cups)? \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_

How often? \_\_\_\_\_

Do you want to lose weight? \_\_\_\_\_

How much? \_\_\_\_\_

How long do you want to live? (circle and check one).

60 \_\_\_\_\_ As long as I'm healthy and not a burden to others

65 \_\_\_\_\_ Whenever my number's up

70 \_\_\_\_\_ Forever

75 \_\_\_\_\_ It's already enough

80

85

90

100+

## IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Who is your Med. Doctor? \_\_\_\_\_ Phone #: \_\_\_\_\_

## HEALTH HISTORY

### Are you taking any of the following medications?

- Nerve pills    Pain killers (including aspirin)    Muscle relaxants    Stimulants  
 Blood Thinners    Tranquilizers    Insulin    Blood Pressure Meds  
 Cholesterol Meds    Other(s) \_\_\_\_\_

### Have you ever had any of the following diseases/medical conditions(s)?

- |                                |                             |                       |
|--------------------------------|-----------------------------|-----------------------|
| Y N Heart Attack / Stroke      | Y N Heart Surg./Pacemaker   | Y N Heart Murmur      |
| Y N Congenital Heart Defect    | Y N Mitral Valve Prolapse   | Y N Artificial Valves |
| Y N Alcohol / Drug Abuse       | Y N Venereal Disease        | Y N Hepatitis         |
| Y N HIV+ / AIDS                | Y N Shingles                | Y N Arthritis         |
| Y N Frequent Neck Pain         | Y N Emphysema/Glaucoma      | Y N Anemia            |
| Y N High/Low Blood Pressure    | Y N Bulged Discs            | Y N Rheumatic Fever   |
| Y N Severe/Frequent Headaches  | Y N Kidney Problems         | Y N Ulcers/Colitis    |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems          | Y N Asthma            |
| Y N Diabetes / Tuberculosis    | Y N Difficulty Breathing    | Y N Chemotherapy      |
| Y N Lower Back Problems        | Y N Artificial Bones/Joints |                       |
- Y N Psychiatric Disorder (Please Specify): \_\_\_\_\_  
Y N Cancer (Please Specify): \_\_\_\_\_

If you circled yes to any of the above conditions, please explain: \_\_\_\_\_

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

List previous surgeries/treatments with dates: \_\_\_\_\_

List any **past** serious accidents with dates: \_\_\_\_\_

What is your stress level on a scale of 1-10? \_\_\_\_\_

What is the quality of your sleep?  Good  Fair  Poor

How many bowel movements do you have per day? \_\_\_\_\_ week? \_\_\_\_\_



## IMPORTANT HEALTH INFO

- Family Health History:**  Cancer  
 Depression    Diabetes    Arthritis  
 Digestive/Gallbladder Problems  
 ♥ Disease    Other \_\_\_\_\_

**Do you smoke?**  No    Yes  
How Much? \_\_\_\_\_ How Long? \_\_\_\_\_

**What is your height?** \_\_\_\_\_ ft. \_\_\_\_\_ in.

**What is your current weight?** \_\_\_\_\_ lbs.

**What is your blood type?**   **A**   **B**   **AB**   **O**

**For women:** Are you taking Birth Control?

Yes    No

Are you Pregnant?

No    Yes/How long? \_\_\_\_\_

Nursing?  Yes    No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed to assess my condition and care for me in the office. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- **OFFICE POLICY:** Scheduled appointments must be made up in the same week, or a cancellation fee of \$25 will be charged.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_